

Massachusetts Board of Registration in Pharmacy  
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**Controlled Substance Registration (CSR) Application**  
**for Automated Dispensing Devices (ADD)**  
**(MA resident retail pharmacies only)**

In accordance with M.G.L. c. 94C, § 7, I hereby apply for a Controlled Substances Registration for an Automated Dispensing Device ("ADD") to secure and dispense medications in a MA healthcare facility.

**Name of Pharmacy** \_\_\_\_\_ **License No.** \_\_\_\_\_  
**Street Address** \_\_\_\_\_  
**City/Town** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_  
**Tel. No.** \_\_\_\_\_ **E-mail** \_\_\_\_\_

**Location of ADD (each device needs a separate application)**

**Name of Facility** \_\_\_\_\_  
**Street Address** \_\_\_\_\_ **Floor** \_\_\_\_\_  
**City/Town** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Check applicable controlled substance(s)**

☐ Schedule II      ☐ Schedule III      ☐ Schedule IV      ☐ Schedule V      ☐ Schedule VI\*\*

**\*\* Schedule VI: This substance is any prescription drug that has not already been included in Schedules II-V.**

☐ Please send a **check or money order for \$225** payable to the *Commonwealth of Massachusetts*.

**Note:** Do not send cash, foreign currency, or electronic funds transfers. There will be a \$23 handling charge for returned checks. Fees are non-refundable and non-transferable.

**Attestation**

- ☐ I have read, understand, and agree to comply with [Policy 2019-02:Automated Dispensing Device Use](#).  
☐ I understand that if the healthcare facility does not have an on-site pharmacy, the facility must obtain approval for use and placement of an ADD from the facility's licensing body (**provide a copy of approval**).  
☐ I have read and understand the [DEA requirements](#) for installing ADDs in long-term care facilities.

**Signature of MOR** \_\_\_\_\_

**Printed Name of MOR** \_\_\_\_\_

**To be completed by Board**

Check:	Date:	Receipt No:
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